DENTAL HISTORY

Do you have any unhealed or inflamed areas in or around your mouth?	YES	NO
Do you have any growths or sore spots in your mouth?	YES	NO
Do you chew on both sides of your mouth?	YES	NO
Do you have any pain in or near your ears or jaw joints?	YES	NO
Do you habitually clench your teeth during the day or night?	YES	NO
Do you have headaches?	YES	NO
Do you have pain, clicking, or popping when you open or close or chew?	YES	NO
Are your teeth/gums sensitive to hot, cold or sweets?	YES	NO
Do you have problems with food wedging between back teeth when you chew?	YES	NO
Are you experiencing bad breath or a bad taste in your mouth?	YES	NO
How often do you brush? _____ Vigorously or lightly?	YES	NO
Have you been taught to floss? _____ Do you do it?	YES	NO
Is it difficult for you to brush or floss or clean any area of your mouth?	YES	NO
Do you use mouthwash? Why?	YES	NO
How often do you have your teeth cleaned?	YES	NO
Do your gums bleed when you have your teeth cleaned?	YES	NO
Is it painful?	YES	NO
Have you lost any teeth? Why?_____	YES	NO
Do you like the appearance of your teeth and smile?	YES	NO
Do you have any concerns about getting your mouth in shape?	YES	NO

Approximate date of last dental examination_____ Cleaning_____
Was treatment completed?_____

Do you have any dental complaints?

What would you change about your mouth if you had a magic wand and could do whatever you wanted with it?